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Examining Stigma Among Preservice Teachers Following the Completion of a Mental Health Literacy Course

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STIGMA AMONG PRESERVICE TEACHERS

Abstract

This research examined whether a mental health literacy course for preservice teachers reduced mental health stigma and whether there were any meaningful differences in stigma based on gender, BEd program, previous degree, and previous learning about mental health. Preservice teachers from X University participated in a mental health literacy course for ten weeks, which involved education about various topics related to mental health. The teachers were asked to complete a pre-test (N=263) at the start of the course, which included an Opening Minds Stigma Scale (Modgill, Patten, Knaak, Kassam, & Szeto, 2014), measuring mental health stigma. Similarly, the teachers were asked to complete the same measure at the completion of the course (N=256). The teachers' pre- and post-test scores on the scale were compared to measure changes in stigma. The findings demonstrated an overall decrease in stigma across teachers at the completion of the course. Moreover, the results showed differences in stigma based on gender, BEd program, previous degree, and previous learning about mental health. Findings from this research have both theoretical and practical implications and are important for teacher education and counsellors.

Keywords: stigma, preservice teachers, mental health course, mental health literacy

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Examining Stigma Among Preservice Teachers Following the Completion of a Mental Health
Literacy Course

Chapter 1: Introduction

Mental health has become a growing area of concern as increasing numbers of children and youth have struggled with some form of mental illness (Mental Health Commission of Canada, 2016a). According to the Mental Health Commission of Canada (2016a), approximately 1.2 million children and youth struggle with a mental illness per year, which has significant impacts and has been linked with poorer outcomes socially, academically, and physically (Kutcher, Wei, McLuckie, & Bullock, 2013). Despite the increasing numbers of children and youth affected by mental illness, as few as twenty per cent are properly treated (Mental Health Commission of Canada, 2016a), meaning early intervention is imperative. One means to promote early intervention is through school-based initiatives such as teacher education in mental health to better support children and youth struggling with mental health issues.

Teacher education in mental health may aid teachers in becoming knowledgeable about mental health issues and position these caring professionals to be part of the pathway to identification and treatment. Teacher education in mental health strives to increase teachers' mental health literacy. Mental health literacy (MHL) includes four components: learning about positive mental health, becoming knowledgeable about the different types of mental health disorders, promoting positive attitudes towards mental health and reducing stigma, and promoting access to resources and help seeking behaviors (Kutcher et al., 2013). One aspect of MHL involves targeting stigma of mental health. Stigma of mental health is present among helping professionals and has negative implications for supporting individuals with a mental illness (Overton & Medina, 2008). Stigma can be defined as "the co-occurrence of labeling,

stereotyping, separation, status loss, and discrimination in a situation where power is exercised” (Modgill, Patten, Knaak, Kassam, & Szeto, 2014, p. 1). Stigma manifests across multiple domains and can be a significant barrier to seeking help, which means it is important to target given teachers’ fundamental role in working with students. Thus, it is important that mental health education involves targeting and reducing stigma among teachers.

There is little research on the presence of mental health stigma among teachers, which is the focus of the current study. This study reviews the available literature on the significance of teacher-student relationships, stigma, barriers to helping students in the classroom, and mental health education. The methodology, results, discussion, and implications for this study will also be reviewed.

Chapter 2: Literature Review

The Role of Teachers in Students’ Lives

Children and youth spend over thirty hours a week at school, with the majority of the time being spent in the classroom (Wei & Kutcher, 2011). Teachers work with students on a constant basis, observing their behavior daily and play a significant role in the social and cognitive development and education of their students (Davis, 2003; Rodger, et al., 2014). Research has examined the teacher-student relationship using an attachment theory lens, which suggests that the relationship is an extension of a child’s relationship with their parents. Using this theory, teachers reflect a ‘secure base’ through which acceptance, responsiveness, availability, and warmth in the classroom positively affect students’ learning and development (Longobardi, Prino, Marengo, & Settanni, 2016). Positive teacher-student relationships are described as “supporting children’s motivation to explore as well as their regulation of social, emotional, and cognitive skills” (Davis, 2003, p. 209). The quality of a teacher-student

relationship is fundamental to a student's wellbeing across all age groups (Davis, 2003). In fact, Baker (2006) found that vulnerable children with developmental difficulties who had a close relationship with their teacher were doing significantly better in school compared to children with developmental difficulties who did not have that close relationship with their teacher. Thus, positive teacher-student relationships help students flourish in the classroom whereas negative teacher-student relationships can have negative implications on student success.

Furthermore, research has shown that positive teacher-student relationships have positive effects on school adjustment across all age groups. That is, teachers' emotional support, closeness with students, and interest in meeting students' needs are important predictors in making school transitions easier for preschoolers, elementary students, and students entering high school (Baker, 2006; Longobardi et al., 2016). Baker (2006) found that adjustment in the classroom for elementary aged students was positively correlated with the relationship a student had with their teacher. Positive teacher-student relationships influenced adaptive school outcomes including social skills, work habits, and grades. On the other hand, a teacher-student relationship characterized by conflict, had negative effects on a student's school adjustment (Baker, 2006). Moreover, the transition from middle school to high school is the most difficult adjustment for students, characterized by more independence, higher expectations, and change in routine. Since this transition is a significant time of change, the quality of a teacher-student relationship is important to students' academic achievement, behavior, and social and emotional wellbeing (Longobardi et al., 2016). Thus, the quality of teacher-student relationships are important predictors to how students adjust in the classroom.

Overall, teachers are considered significant and influential figures in students' lives and have an impact on their development, education, and wellbeing. Research has supported the

benefits of positive teacher-student relationships and the impact it can have overall (Davis, 2003). In considering positive teacher-student relationships, it is important to recognize that the presence of stigma can be a barrier to forming positive relationships and prevent teachers from providing the proper support to students (Moses, 2010). Research has found that stigma among teachers is not limited to mental health. Teachers demonstrate stigma based on race, expectations, and academic achievement. Stigma in these areas impacts teachers' discipline style, their beliefs about students' capabilities, and the support and education provided (Peterson, Rubie-Davies, Osborne, & Sibley, 2016; Timmermans, DeBoer, & VanderWerf, 2016). Thus, stigma among teachers must be addressed given the benefits positive teacher-student relationships can have across students' development and the negative implications stigma can have on such relationships. This means stigma is crucial to target in the school setting.

Stigma and Mental Illness

It is first important to define stigma and understand how it operates, which will be done using the mental illness stigma theory. Stigma associated with mental health continues to be a challenge faced by those struggling with mental illnesses, despite increasing efforts to reduce such attitudes (Mental Health Commission of Canada, 2016b). Mental illness stigma can be defined as, "the culmination of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and enact behaviors of discrimination against people with mental illness" (Pinto, Hickman, Logsdon, & Burant, 2012, p. 48). Mental illness stigma affects people with mental health concerns in significant ways. Not only do individuals with mental illnesses have to deal with the repercussions of the disorder but also the effects of stigma. For one, stigma creates a barrier to accessing treatment, which limits individuals' abilities to manage their symptoms (Corrigan & Watson, 2002b; Pinto et al., 2012).

Corrigan & Watson's (2002b) mental illness stigma theory provides a framework through which the stigma of mental health can be understood. This theory was chosen based on its framework and concepts and its relation to the broader context (i.e., school, education) in this research. First, two types of stigma are outlined, public stigma and self-stigma, which can further be explained by three components: stereotypes, prejudice, and discrimination. Stereotypes refer to beliefs and social knowledge structures about a specific group that are learned and accepted by the general public (Corrigan & Watson, 2002a). Stereotypes are considered efficient because they influence impression formations and expectations about members belonging to specific groups and can be formed in a quick manner. Prejudice refers to the actual endorsement of stereotypes, which often leads to negative emotional reactions such as fear. Not every individual agrees with stereotypes and thus, those who do are considered prejudice, which leads to discrimination (Corrigan & Watson, 2002b). Discrimination involves a behavioral response, such as avoiding contact with people who have a mental illness. Similarly, self-stigma can also be explained by these three components. Self-stigma might involve individuals with mental health issues internalizing beliefs about mental illness, negative emotional responses such as low self-worth, and behavioral responses such as limiting help seeking behavior (Corrigan & Watson, 2002a).

Public stigma refers to the general public's attitudes towards people with mental illnesses. Research demonstrates that stigma is still an endorsed attitude among a number of people (Mental Health Commission of Canada, 2016b; Overton & Medina, 2008). Stigmatizing attitudes are not only present among the general population but also include professionals in mental health disciplines (Corrigan & Watson, 2002b). Specific misconceptions about mental illness can be defined by fear, exclusion, irresponsibility, and childlike behavior. The

endorsement of stereotypes leads to behavioral reactions such as avoidance, withholding help, and isolated institutionalization (Corrigan & Watson, 2002b). On the other hand, self-stigma is the internalization of stigma among those living with mental illnesses. Self-stigma may occur as a result of the public's stigma towards mental illness, which has significant impacts on a person's self-efficacy and sense of self. Self-stigma can manifest itself in three ways: an individual may experience a harmed sense of self leading to low self-esteem, an individual may become angry, reacting to the inequality they have faced, or an individual may remain indifferent to the stigma experienced (Corrigan & Watson, 2002b).

According to this model, public stigma must be addressed first. Three strategies have been proposed to address and reduce public stigma: protesting, education, and contact. Protesting includes challenging and debunking stereotypes about mental illness in order to send messages to the general public that their representations of mental health are inaccurate (Corrigan & Watson, 2002b). Education involves providing information and teaching the general public about mental health, "so that the public can make more informed decisions about mental illness" (Corrigan & Watson, 2002b, p. 17). Education has been found to be effective in reducing stigma and promoting positive attitudes. Lastly, having the general public come in contact and interact with people living with mental illnesses can be effective in reducing stigma (Corrigan & Watson, 2002b). Based on this theory, Corrigan (2004) suggests that targeting stigma directly is the most effective means for reducing stigma. The author suggests targeting influential social groups such as health care providers, the media, and teachers, who can negatively affect those with mental health issues, through providing education and taking action to reduce stigma.

In relating this theory to the present research, the school setting can be seen as a public sphere with various people coming together, which makes it a setting to examine the presence

and impact of public stigma. In the school setting, different functions involve working, playing, and learning, in public places such as the classroom, library, playground, gym, and cafeteria. The function of school is ground for stigma to emerge but also for intervention to be implemented (Corrigan & Watson, 2002b). In fact, Corrigan & Watson (2002b) state that targeting social groups such as teachers, is significant in beginning to change attitudes towards mental health given their position to make a difference in childrens' lives. This is especially important to consider given that students are developing throughout the school years, which is when the presence of mental illnesses begin to emerge (Kutcher et al., 2013). This is a critical point given that the presence of public stigma of mental health can lead to self-stigma and be detrimental to a student's development. Thus, it is crucial that the school setting is used to implement interventions that address and minimize stigma, given the impact it can have in various ways.

Overall, Corrigan & Watson's (2002b) mental illness stigma theory is useful in demonstrating how stigma operates and how stereotypes are quick and efficient means for forming impressions and guiding behavior towards those with mental health issues. Further, this theory draws attention to how mental health professionals also endorse such attitudes, which demonstrates how embedded stigma is within society. Lastly, this theory is useful in providing strategies to target stigma. Thus, this theory was used to guide the rationale and methodology for this research.

The Role of Stigma

Stigma has a pervasive effect on people living with a mental illness. Overton & Medina (2008) report that stigma is present among helping professionals, who subscribe to stereotypes about mental health. Research has shown that stigma of mental health is present among counsellors, pharmacists, and medical students (Overton & Medina, 2008; Papish, Kassam,

Modgill, Zanussi, & Patten, 2013; Patten et al., 2012), which is concerning as their roles involve helping individuals with mental health issues.

Stigma among helping professionals can be especially detrimental as it can create barriers to treatment for those seeking services, reduce patient care, facilitate oppression, and diminish self-esteem. Stigma of mental health among helping professionals reinforces and maintains rather than reduces stigma, which can lead individuals into feeling silenced, shamed, and rejected (Overton & Medina, 2008; Papish et al., 2013; Patten et al., 2012). Common beliefs among helping professionals include individuals with mental health issues are incompetent and to be feared (Overton & Medina, 2008). This is important to consider as stigma can negatively affect the relationship between people with a mental illness and helping professionals, further isolating them (Patten et al., 2012). Further, this demonstrates that those within helping roles are not immune to biases about mental health and how stigma is a generalized attitude among a number of people, making it critical to address. Current research on mental health stigma among teachers as helping professionals is scarce, which represents a gap in the literature that was addressed.

Stigma of mental health among teachers is important to consider as it could create a barrier to forming supportive teacher-student relationships. Moses (2010) was interested in examining the impact of stigma in the school setting and interviewed 60 adolescents diagnosed with a mental illness regarding their experiences. Sixteen of the participants reported negative treatment from teachers and staff at school due to their mental illness. Participants reported feeling stigmatized through being feared, blamed, disliked, rejected, and avoided (Moses, 2010). Their experiences with teachers led to feelings of isolation and frustration. On the other hand, ten adolescents reported positive treatment from teachers and had a much different experience. These participants described their teachers as supportive and flexible in meeting their needs

(Moses, 2010). Some reported special treatment from teachers, which led to feelings “that they care about them, hold them to high expectations, root for their success, and express support and understanding” (Moses, 2010, p. 990). Furthermore, Moses (2010) looked at the impact of stigma from peers, which is also relevant in the school setting. The majority of participants reported experiencing some or substantial stigma from their peers, which included harassment, ridicule, rejection, and isolation as a result of their mental illness. These findings demonstrate that mental illness stigma at school whether it be from teachers or peers, can pose a barrier to forming supportive relationships in the school setting and have detrimental effects on a student’s overall wellbeing (Moses, 2010). Therefore, it is important to address mental illness stigma within schools to help better support students dealing with these issues.

Stigma has been found to develop at a young age through social influences (i.e., parents, teachers), providing schools with another avenue to promote positive attitudes (Cooke, King, & Greenwood, 2016). Stigma can be mitigated through educating people about mental health, including students (Kutcher, Wei, & Morgan, 2015). However, Mueller, Callanan, & Greenwood (2015) did an extensive search on the available literature pertaining to teachers’ discussion of mental health with primary aged children and found few articles addressing this topic. Cook et al. (2015) addressed this gap and examined teachers’ roles in discussing mental health with their students and the factors contributing to the discussion. Fifteen elementary school teachers from the United Kingdom took part in semi-structured interviews. The authors found that none of the teachers were discussing mental health in their classrooms, which was influenced by their emotions and beliefs (Cooke et al., 2016). Teachers reported fear of discussing mental health because of a lack of knowledge, lack of experience, eliciting unwanted behavior among children, fear of parental complaints, and fear of students with mental health issues. Teachers reported

beliefs that only some people are affected, children need to be protected, children are too young to know about mental health, and teaching about mental health is hard (Cooke et al., 2016).

Further, teachers reported that mental illness is stigmatized and noted self-stigma in discussing their own mental health, which was believed to produce negative outcomes. Teachers' emotions and beliefs led them to avoid discussing mental health with their students. Teachers believed in sticking to the curriculum to protect themselves and to avoid negative consequences that could result from the discussion of mental health (Cooke et al., 2016).

Cooke et al. (2016) concluded that the absence of mental health discussion in the classroom is due to the stigma that surrounds mental health. The teachers did not directly admit to having stigmatizing attitudes but instead, mentioned more generally how mental illnesses are stigmatized. However, reviewing the above findings, it is evident that stigma of mental illness underlies their beliefs and emotions. This is important to consider as due to their professionalism, teachers might be reluctant to admit the presence of stigma. The absence of discussion in the classroom reinforces the stigma and belief that discussing mental health should be avoided, which inhibits children from learning about mental health. Teachers' discomfort in discussing mental health with students influences the suppression of positive messages and leads to missed opportunities to reduce negative attitudes (Mueller et al., 2015). This study supports the mental illness stigma theory in demonstrating how stereotypes, prejudice, and discrimination operates to create and perpetuate stigma. The teachers' lack of education about mental health demonstrates how with little education, people can form inaccurate representations of people with mental illnesses (Corrigan & Watson, 2002b). Thus, education, as suggested by the mental illness stigma theory, can be an effective means to target stigma.

Lastly, stigma is often implicit and hidden, which can be influenced by a social

desirability bias. Social desirability bias can be defined as the tendency of individuals to be influenced by what others think of them and thus, respond in ways that make themselves look favorable (Crowne & Marlowe, 1960). This means that stigma could be operating unconsciously, which might lead individuals to perceive the absence of mental health stigma. Overall, the presence of stigma is fundamental to consider with helping professionals, as their roles involve helping those with mental illnesses. Thus, mental health education should include targeting and reducing stigma, given the negative implications it can have across a number of domains.

Barriers to Helping Students in the Classroom

Teachers constant interaction with students over time places them on the “front line” of their mental health concerns (Rothi, Leavey, & Best, 2008). Teachers have the ability to positively impact students’ mental health and thus, school-based initiatives become important in addressing and supporting the mental health needs of students (Kutcher et al., 2013; Reinke, Stormont, Herman, Puri, & Goel, 2011). The problem however, is that teachers may not be well equipped to deal with their students’ mental health needs due to a lack of knowledge and training, and stigma that still persists.

Reinke et al. (2011) conducted a study examining elementary school teachers perceived roles and barriers related to mental health in the classroom, whereby two-hundred and ninety-two teachers from five education boards completed an online survey addressing mental health concerns, knowledge, skills, training, barriers, reasons for the lack of treatment, and the role of the school. The results demonstrated that a majority of teachers reported having taught a child with a mental health concern in their classroom (e.g., hyperactivity); importantly, the majority of teachers reported a lack of knowledge and skills necessary to support children with mental health needs. The authors reported that the barriers to helping children included insufficient training and

funding for mental health and a lack of mental health professionals at school; teachers also reported a need to understand mental health and training on classroom techniques and strategies to address mental health in the classroom (Reinke et al., 2011). These findings demonstrate the importance of training teachers in mental health in order to reduce the perceived barriers to helping children with mental health concerns. Walter, Gouze, & Lim (2006) found similar results in their study, supporting the need for teachers to receive training and education in mental health. The teachers in their study wanted to help students and reported actively seeking out their own information about mental health through books and workshops. Thus, mental health education is desired amongst teachers in order to move towards promoting positive mental health in the classroom and to enhance the wellbeing of their students (Walter et al., 2006).

There is a clear need for more teacher education programs that support teachers in learning about mental health. To examine the availability of education in mental health for teacher candidates, Rodger et al. (2014) examined 700 courses related to mental health that were offered to teacher candidates in Canadian Bachelor of Education programs. The courses were examined based on the inclusion of specific mental health literacy criteria, which the authors developed. The course descriptions for each course were examined based on four components: the description of the course included specific words (e.g., mental, health, stress, wellbeing), practice and implementation was incorporated such as learning about strategies, relationship building with students was included, and the course title specified that it was about mental health (Rodger et al., 2014). Based on this criteria, a score from zero to four was given to each course. Out of the 700 courses reviewed, 217 received a score between one to four and only two received a score of four (Rodger et al., 2014). Based on these findings, Rodger et al. (2014) noted the

need for more courses on mental health in Canadian Bachelor of Education programs and suggested making them compulsory for teacher candidates to increase mental health competency.

The above studies note the lack of education, knowledge, and training in mental health as barriers to teachers helping students with mental health needs in the classroom. Training teachers in mental health to reduce the perceived barriers becomes important in empowering teachers to intervene and provide assistance to children and youth struggling with mental health concerns at school.

Educating Teachers in Mental Health

Teacher education in mental health is important to bridge the gap between the amount of education teachers receive and their ability to support students with mental health issues in the classroom. Mental health education is one means through which barriers to helping could be eliminated, stigma could be reduced, and students could be better supported. Weston, Anderson-Butcher, & Burke (2008) suggest that education in mental health is needed for both pre-service and in-service teachers since “social-emotional dysfunction...is clearly a barrier to academic achievement – a learning problem that requires school-based intervention and support” (p. 27). Weston et al. (2008) developed a framework based on six principles, “to assist teachers with building the knowledge and skills necessary to feel effectual in meeting the needs – social and emotional as well as cognitive – of all students” (p. 32).

Principle one involves learning and understanding the key policies and laws that govern teaching such as guidelines about confidentiality. Principle two involves acquiring knowledge and skills about learning supports which encourage educational and overall wellbeing. Principle three involves acquiring knowledge and skills in assessing and meeting students’ needs with appropriate outcomes (Wetson et al., 2008). Principle four involves the ability to effectively

communicate and build interpersonal relationships with students, parents, and colleagues. Principle five involves addressing multiple systems (e.g., communities, families) to increase students' overall wellbeing. Lastly, principle six involves teachers meeting their own personal and professional growth and wellbeing (Wetson et al., 2008). The authors suggest that the acquisition of these six principles should help lead teachers towards mental health competence, better prepare them to meet the needs of their students, and guide their relationships with them. Thus, these six principles can help guide educational programs in mental health for teachers to better prepare them in meeting the needs of their students as well as their own (Wetson et al., 2008).

Noting the importance of educating teachers in mental health, Kutcher et al. (2013) examined the effects of training on teachers' knowledge and attitudes. The authors wanted to train teachers on the use of the *Mental Health Curriculum Guide (MHCG)* and improve teachers' mental health literacy (Kutcher et al., 2013). MHCG is a curriculum, developed in Canada for teachers to implement in their high school classroom as a way to address student mental health. The MHCG is meant to increase teacher and student mental health literacy, reduce stigma of mental health, and improve access to mental health resources (Kutcher et al., 2013). One full day of training was provided to 89 grade nine teachers from one school board located in Nova Scotia. The study employed a pre- and post-test measure using a thirty-item questionnaire assessing knowledge and attitudes. Teachers completed the pre-test before the training began and completed the post-test the same day, at the end of training (Kutcher et al., 2013).

The results demonstrated that teachers' perceived knowledge and attitudes significantly improved following the training. However, the authors found that teachers' attitudes were highly positive at the pre-test and improved further at the post-test (Kutcher et al., 2013). It is important

to note that the MHCG was developed for high school teachers and youth, which might include different content than mental health literacy for elementary school teachers and children with mental health issues. Wei, Kutcher, & MacKay (2014) replicated these findings in their study, which involved a larger sample size and greater number of schools targeted in receiving the training. Furthermore, Kutcher, Wei, & Morgan (2015) implemented similar training for teachers in a large school board in Ontario and examined changes in high school students' knowledge and attitudes following the implementation of the program in their classroom. The results supported that the MHCG is effective in improving students' mental health knowledge and attitudes, which demonstrates that mental health education is beneficial for both teachers and students. Overall, these studies demonstrate the importance of mental health literacy training in improving teachers' knowledge about mental health, reducing stigma, and promoting positive attitudes.

Thus far, it has been demonstrated that teachers play a fundamental role in students' development and education, which places them in a position to support students' mental health needs. However, stigma continues to persist and creates barriers to forming supportive teacher-student relationships. Education is one means through which both knowledge and stigma can be targeted. Research has demonstrated that mental health education is an effective means to improving teachers' mental health knowledge and attitudes, which has positive implications for students with mental health issues. The existing literature presented above helped guide the rationale and methodology for the present study.

Course Development

This study utilized a mental health literacy course to evaluate its efficacy in reducing stigma. The course, called *Mental Health Literacy-Supporting Socio-Emotional Development*, was developed by Dr. Susan Rodger based on the need for more teacher education in mental

health. Dr. Rodger used principles of inclusion and equity to guide the course overall and recognized the importance of teachers building relationships with their students. The course was designed to address knowledge, equity, inclusion, and stigma. Inclusion in the classroom has become an important principle in education, in order to foster belonging and equity and promote wellbeing (Specht, 2012).

The course was developed using a modified definition of mental health literacy, which is still developing and emerging. The Canadian Alliance on Mental Illness and Mental Health (2008) define mental health literacy as the “knowledge and skills that enable people to access, understand, and apply information for mental health” (pg. 1). This definition bridges the gap between health literacy and mental health literacy, through addressing health promotion. Further, this definition reinforces that mental health literacy is more than providing information but also includes skill development and application. The definition of mental health literacy is context specific and thus, MHL in relation to education is continuing to emerge.

The Present Study

This research aimed to examine stigma among preservice teachers and whether a course on mental health literacy reduced stigma. This involved examining whether there were any meaningful differences in stigma among preservice teachers based on gender, BEd program (i.e., primary/junior, intermediate/senior), previous degree (i.e., social sciences, sciences, arts and humanities, religion and divinity), and previous learning about mental health. Stigma, for the purpose of this study, was defined as “the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a situation where power is exercised” (Modgill et al., 2014, p. 1).

First, based on the mental illness stigma theory, it was hypothesized that a course on mental health literacy would reduce preservice teachers' stigma. Second, for the research question that examined whether there were any meaningful differences in stigma based on gender, BEd program, previous degree, and previous learning, no hypotheses were made. The research question was exploratory in nature since no literature exists on the topic to make informed hypotheses.

Gaps in the Literature

There are gaps noted within the literature that were addressed by the present study. One limitation noted in the studies conducted by Kutcher et al. (2013), Kutcher et al. (2015), and Wei et al. (2014), which examined the effectiveness of mental health literacy training, involved certified teachers working in the field and targeted high school students. The samples involved teachers in the intermediate/senior division and the training content was specific to the high school setting (e.g., mental health among adolescents). This limits our understanding of stigma among teachers across all divisions. The present study involved educating preservice teachers enrolled in all divisions (i.e., primary/junior, intermediate/senior) of a Bachelor of Education program and involved course content that applied to all teachers.

Further, both the training and pre- and post-test in the studies mentioned above were completed in one day. The preservice teachers in the present study learned about mental health over ten weeks and there was considerable time between the pre- and post-test measure, controlling for the testing effect. Third, research shows that stigma is present among helping professionals. There is a lack of research on the stigma of mental health among teachers, who are considered to be in helping roles. The present study addressed this gap and explored the nature of stigma among preservice teachers.

Chapter 3: Methodology

Research Design

This research used a quantitative research design. This research is part of a larger study that involved a pre-and post-test, measuring mental health literacy, self-efficacy, social desirability, coping mechanisms, negative actions, and stigma. The pre-test consisted of demographic questions plus 168 items; these were duplicated for the post-test. However, given the purpose of the present study, the questions that were used constituted the demographic items and the Opening Minds Stigma Scale (Modgill et al., 2014), which measured stigma specifically.

Program Evaluation

This research was a program evaluation, which examined the effectiveness of a mental health literacy course. The ethics board specified that this research fell under the category of program evaluation and granted the researchers with a 'Letter of Exception'. There are various criteria for determining whether research is considered program evaluation. Some of the criteria includes: the course was not developed to answer a specific research question or test a hypothesis; there was no comparison of different groups or interventions; the course did not involve additional burdens; and the course was evaluated with the purpose of improving the structure of the course. Thus, ethics approval was not needed for this research and was deemed as program evaluation.

Participants

Two hundred and seventy-nine second year Bachelor of Education students from X University took the mandatory online course and were asked to complete the survey as part of the course evaluation (i.e., 14% participation mark). Participants differed across demographics (i.e., age, gender, ethnicity). Participants differed in previous degree obtained (i.e., social

sciences, sciences, arts and humanities, religion and divinity), the division within the Bachelor of Education program they were enrolled in (i.e., primary/junior, intermediate/senior), and in the amount of mental health learning acquired before the course. The sampling method for this study was purposive and convenient since the sample size was based on the number of students enrolled in the course and was chosen for the purpose of evaluating the effectiveness of a mental health literacy course for preservice teachers.

Measures

Demographic Information. Students were asked demographic information, which was used as part of the data analysis for this study. The information obtained involved the gender of participants, the BEd program enrolled in (i.e., primary/junior, intermediate/senior), previous degree obtained (i.e., social sciences, child and family studies, psychology, social work, sciences, health sciences, arts and humanities, and religion and divinity), and their previous learning about mental health (See Appendix A).

Opening Minds Stigma Scale. Students were asked fifteen questions related to stigma using the standardized Opening Minds Stigma Scale (Modgill et al., 2014). The scale is a self-report measure and “assesses attitudes and behavioral intentions towards people with mental illness” (Modgill et al., 2014, p. 3). The Opening Minds Stigma Scale was originally developed and used with health care providers. However, the scale was adapted as necessary in order to address preservice teachers and mental health. This involved changing the wording of the questions to make them applicable to teachers. The present study was the first to use this scale with preservice teachers. The items on this scale targeted both public and self-stigma. One example of an item that targeted public stigma states, “More than half of people with mental

illness don't try hard enough to get better" (2014). One example of an item that targeted self-stigma states, "I would be reluctant to seek help if I had a mental illness" (2014).

Preservice teachers rated their responses on a five point Likert scale with values including strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree. Each item was rated from 1-5 based on the student's response. Items were reversed coded as needed. A higher score on the measure reflected a higher stigmatizing attitude whereas a lower score reflected a lower stigmatizing attitude. Students received a total stigma score for both the pre- and post-test, with the highest possible total score being 75 (See Appendix B). The Internal Consistency Reliability for the Opening Minds Stigma Scale was calculated at the pre-test and was acceptable ($\alpha = .86$) and at the post-test and was acceptable ($\alpha = .87$).

Procedure

Students in a Bachelor of Education program were required to take a mandatory online course as part of their degree requirements. Dr. Susan Rodger is part of a national effort, TeachResiliency.ca, that is developing a mental health curriculum for preservice teacher education across Canada, which formed the foundation of the current course. The university is the first university to make a mental health course mandatory for preservice teachers. The course is meant to improve teachers' knowledge and skills in mental health, reduce stigma, promote positive attitudes, and increase feelings of self-efficacy. The course ran for ten weeks and each week, the lecture topic addressed different components of mental health literacy.

The course was divided into two blocks, each five weeks long. Block one began during the fall semester and addressed differences between mental health and mental illness and content generally included mental health at school; the context of the lives of children, youth, and teachers; mental health in the classroom; critical issues; and stress. Block two began during the

winter semester and addressed what to ask, do, and say with regard to mental health. The content generally included learning, teaching, and working; building resilience and responding to challenges for students and teachers; taking action; and creating and leading the mentally healthy classroom. More specifically, stigma was addressed in week four as part of critical issues and the promotion of positive attitudes was integrated in the course content each week (See Appendix C).

Furthermore, the course strived to include an interactive and practical component through assigning preservice teachers a student profile. Preservice teachers were given a student profile based on the division in which they were enrolled in, which contained the name of a student, their picture, and information about their life. Each student profile dealt with unique mental health problems and the preservice teachers received an update about their student weekly. Each week the preservice teachers were expected to complete a quiz based on the learning objectives of the week and the questions pertained to their individual student. Other learning components such as discussion questions were also based on their student profile. This gave preservice teachers indirect contact with children and youth struggling with mental health issues and allowed them to take an interactive role as a teacher in their lives.

The course provided both an educational and contact based approach. Based on the mental illness stigma theory, students received information about mental health, which has been found to be effective in reducing stigma. Second, the student profiles that were assigned to preservice teachers can be viewed as indirect contact with students dealing with mental health issues, which has also been noted by the mental illness stigma theory as a strategy to reduce stigma.

Lastly, preservice teachers took the pre- and post-test measure as part of the course requirements. Preservice teachers were able to access the pre- and post-test through the university's student portal and had one week prior to the start of the course to complete the pre-test. The overall pre- and post-test consisted of 168 items and took approximately 20 minutes to complete. Consent was implied for the purpose of this study, as the survey was online and students were given information about completing the survey before doing so from the course instructor. Similarly, the post-test was available for students to take after the completion of the course for one week through the student portal. The university's student portal is an online management platform, in which students can access course content for each course being taken in a semester. Each student has a unique user ID and password to login to the student portal. Each student was expected to use the student portal to access the course content including readings, quizzes, discussion forums, and assignments. Preservice teachers received a fourteen percent participation mark for completing the pre- and post-test survey (i.e., seven percent each time).

Chapter 4: Results

The present study aimed to examine whether stigma among preservice teachers changed following the completion of a mental health literacy course and whether there were any meaningful differences in stigma based on gender, BEd program, previous degree, and previous learning about mental health. Table 1 provides a summary of the descriptive statistics for each variable across the pre- and post-test.

Two-hundred and sixty-three preservice teachers completed the pre-test at the start of the course in October. The mean at the pre-test was $M=30.35$, ($SD=7.96$), with a range of 16-63. At the completion of the course in February, two-hundred and fifty-six preservice teachers

completed the post-test. The mean at the post-test was $M=28.81$, ($SD=8.15$), with a range of 15-60.

Table 1

Descriptive Statistics for Preservice Teachers at the Pre- and Post-Test on the Opening Minds Stigma Scale

Variable	<u>Sample Size</u>		<u>Mean</u>		<u>Standard Deviation</u>	
	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test
Overall Stigma Score	263	256	30.35	28.81	7.96	8.15
Gender						
Male	61	56	33.02	31.38	8.68	10.05
Female	199	196	29.56	28.14	7.60	7.43
BEd Program						
Primary/Junior	164	159	29.54	28.75	7.70	8.35
Intermediate/Senior	97	94	31.71	28.64	8.30	7.61
Previous Degree						
Social Sciences, Child & Family Studies, Psychology, Social Work	74	71	29.91	28.31	7.43	7.89
Sciences & Health Sciences	55	55	30.11	28.15	7.77	7.43
Arts, Humanities, Religion, & Divinity	99	97	30.77	29.43	8.96	8.81
Previous Learning about Mental Health						
Yes	187	183	29.56	28.52	7.85	8.30
No	76	73	32.32	29.53	7.94	7.78

To answer the research questions, “does stigma reduce following the completion of a mental health literacy course?” and “does stigma differ based on gender, BEd program, previous degree, and previous learning about mental health?”, the data were analyzed using a repeated measure MANOVA. All assumptions were met for MANOVA, with the exception of equal sample sizes. This is considered to be accepted because it reflects the nature of teaching, as a female dominated profession. The dependent variable across all measures was total stigma score. Students who did not complete the stigma scale at both the pre- and post-test were excluded from these analyses. Results can be found in Table 2.

First, it is important to note that the observed power when examining the reduction of stigma based on time (i.e., pre- and post-test), was adequate at .88. Next, results demonstrate a significant main effect of time, $F(1, 191) = 9.82, p < .001$ and a significant interaction between time and gender, $F(1, 191) = 8.38, p < .001$ and time and BEd program, $F(1, 191) = 6.47, p < .05$ such that time and gender and time and BEd program affected total stigma scores (See Figure 1 and Figure 2). A post hoc analysis for previous degree was completed. However, the interaction between time and previous degree was not significant, $F(2, 191) = 2.10, p > .05$ (See Figure 3). It is important to note that the interaction between time and previous learning about mental health approached significance, $F(1, 191) = 3.78, p = .053$ (See Figure 4).

Table 2

Repeated Measure MANOVA

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	<i>Partial Eta</i>	<i>Observed Power</i>
time	1	207.52	207.52	9.82	.002	.049	.876
time*gender	1	177.04	177.04	8.38	.004	.042	.821
time*BEdProgram	1	136.70	136.70	6.47	.012	.033	.716
time*PreviousDegree	2	88.57	44.28	2.10	.126	.021	.427
time*MHPreviousLearning	1	80.08	80.08	3.79	.053	.019	.491

Note. Significant at $p < .05$.

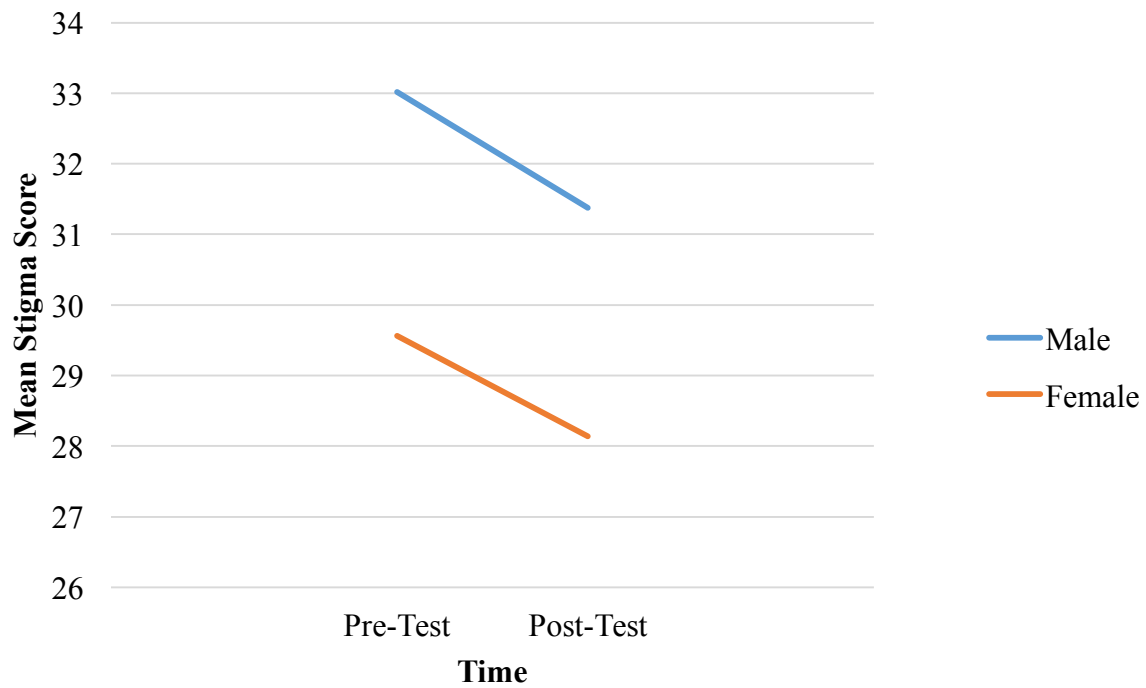


Figure 1. Mean Stigma Scores at the Pre- and Post-Test based on Gender

This graph demonstrates the significant interaction between time and gender. Males had higher stigma at the pre-test than females. At the post-test, both males' and females' perceived stigma reduced. However, males' stigma remained higher than females at the post-test.

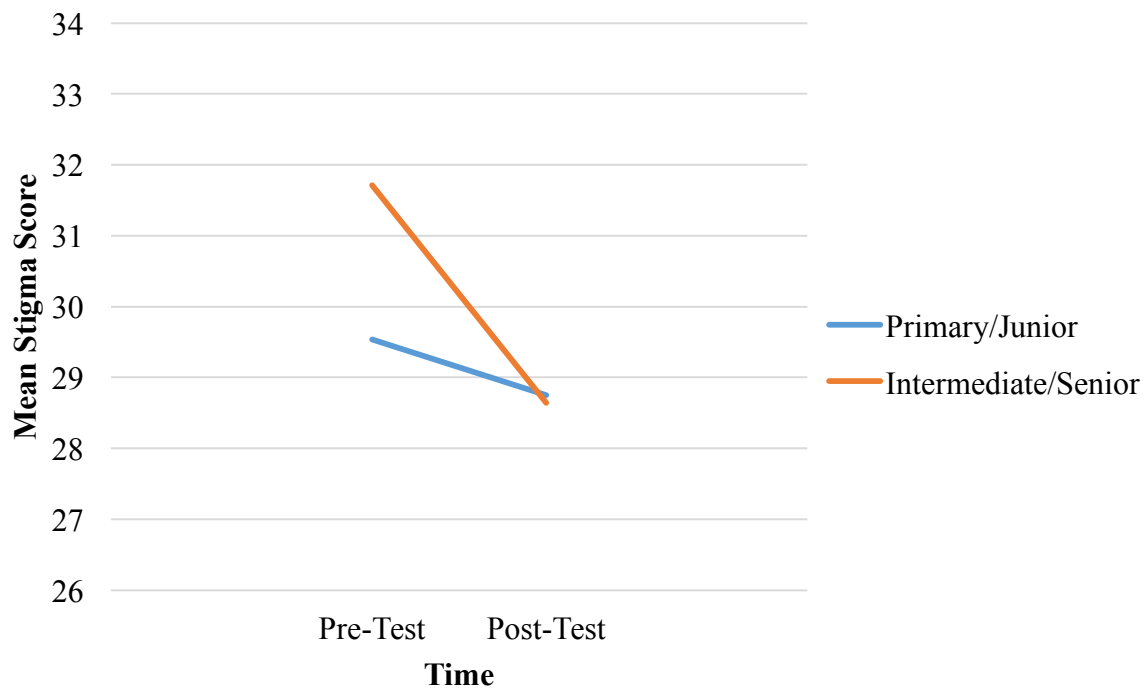


Figure 2. Mean Stigma Scores at the Pre- and Post-Test based on BEd Program

This graph demonstrates a significant interaction between time and BEd program. Those in the intermediate/senior program had higher stigma at the pre-test than those in the primary/junior program. At the post-test, those in the primary/junior and intermediate/senior programs showed similar mean stigma scores, bridging the gap that was present at the pre-test.

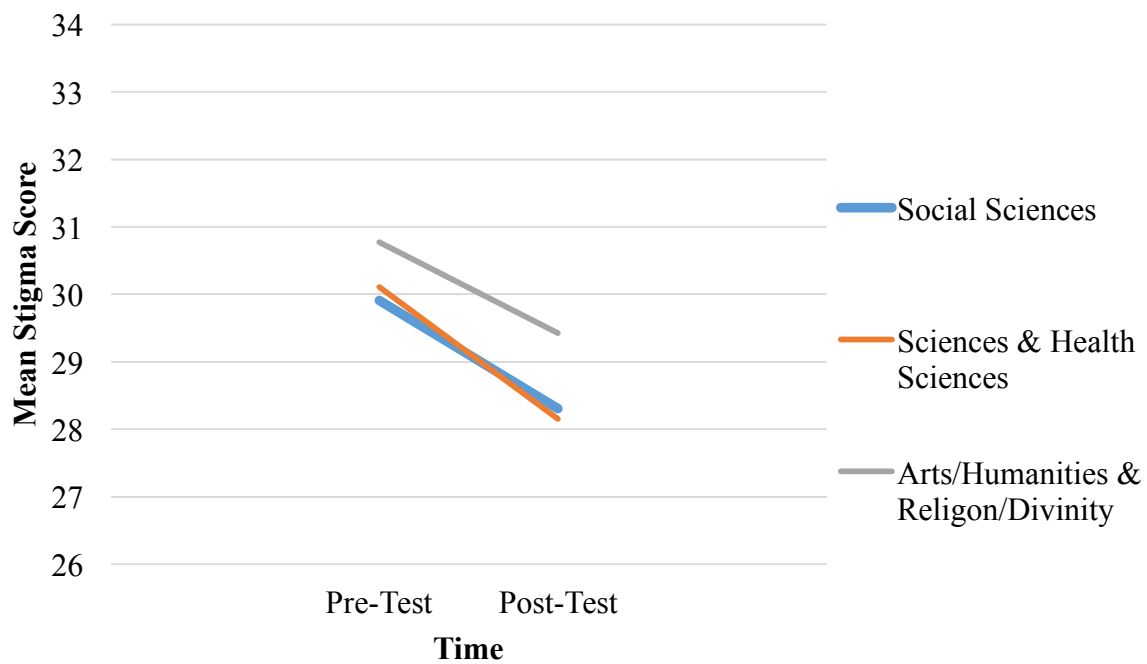


Figure 3. Mean Stigma Scores at the Pre- and Post-Test based on Previous Degree

This graph shows the interaction between previous degree and time. This finding was not significant. Those with a previous degree in arts/humanities and religion/divinity show higher stigma at the pre-test and post-test than those in the social sciences and sciences. Those in the sciences and social sciences have similar mean stigma scores at both the pre- and post-test.

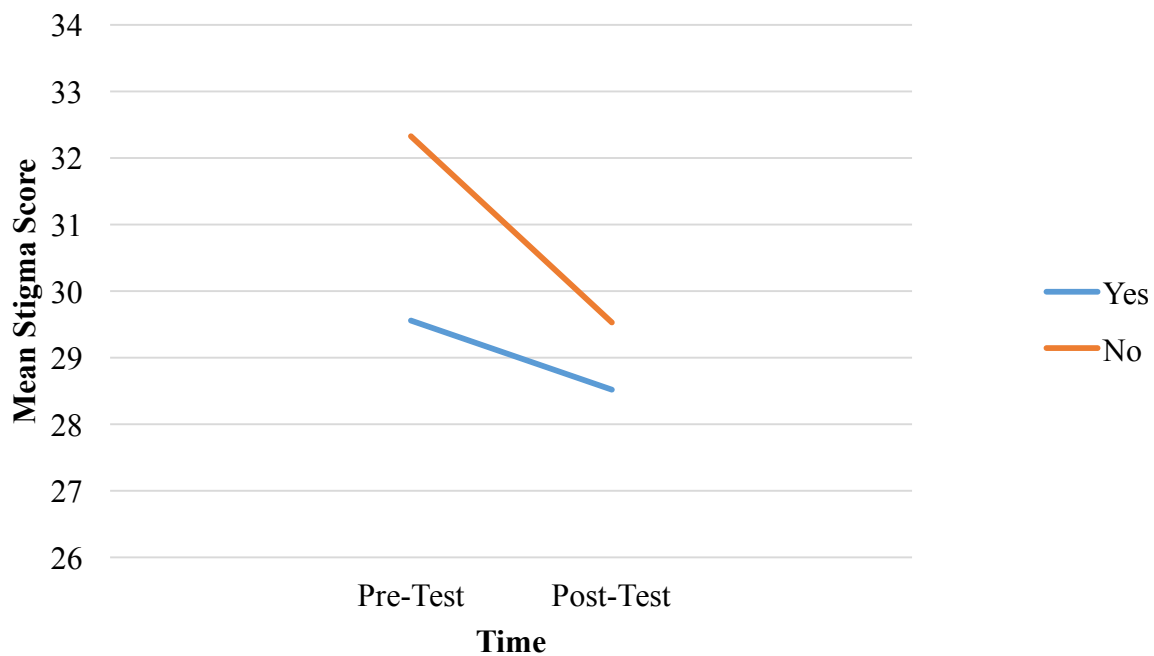


Figure 4. Mean Stigma Scores at the Pre- and Post-Test based on Previous Learning about Mental Health

This graph shows the interaction between time and previous learning about mental health, which approached significance. Those with no previous learning about mental health had higher stigma at both the pre- and post-test than those with previous learning about mental health. However, both groups show a reduction in stigma at the post-test.

Chapter 5: Discussion

This research aimed to examine whether stigma among preservice teachers reduced following the completion of a mental health literacy course. Moreover, whether stigma differed based on gender, BEd program, previous degree, and previous learning about mental health was examined. The purpose of this research was to evaluate the mental health literacy course and its effectiveness in reducing stigma among preservice teachers. For the purpose of this research, stigma was evaluated given the significant barrier it can create in forming positive teacher-student relationships. In addition, there is limited research in the area of mental health stigma among teachers and thus, this study addressed this gap in the literature.

Preservice teachers from X University completed a mandatory mental health literacy course for ten weeks, which involved various topics, discussions, and assignments related to mental health including stigma. The teachers were asked to complete the Opening Minds Stigma Scale (Modgill et al., 2014), which measured mental health stigma. First, it was hypothesized that stigma among preservice teachers would shift following the completion of a mental health literacy course. Second, there was no hypotheses made for the research question examining whether stigma differed based on different variables (i.e., gender, BEd program, previous degree, previous learning). There was no research that existed to inform the hypotheses.

In examining the results, it was found that the findings were consistent with our first hypothesis. The findings demonstrated that following the completion of the mental health literacy course, preservice teachers' overall stigma significantly decreased from the pre- to the post-test. These findings are consistent with Kutcher et al. (2013) and Wei et al.'s (2014) findings, in which mental health literacy increased positive attitudes towards mental health among practicing teachers. Our findings extend Kutcher et al. (2013) and Wei et al.'s (2014)

findings and support that mental health literacy for preservice teachers is also helpful in reducing stigma.

Next, for the exploratory hypotheses, stigma was examined based on different variables. First, the results demonstrated that both males' and females' self-reported stigma reduced following the completion of the course. However, it was found that males had higher stigma than females at both the pre- and post-test. The number of females in this research was higher than males, however, this reflects the nature of the profession as teaching is female dominated. Second, the results demonstrated that preservice teachers in the intermediate/senior division had higher stigma than those in the primary/junior division at the pre-test. Those in the intermediate/senior division showed the greatest reduction in stigma at the post-test, compared to those in the primary/junior division.

Third, the results demonstrated no significant difference in stigma at the pre- and post-test based on previous degree. However, preservice teachers with a previous degree in the arts and humanities and religion and divinity programs had the highest stigma at both the pre- and post-test compared to those with a previous degree in the social sciences and sciences. Those in the sciences showed the greatest reduction in stigma at the post-test. It would be interesting to further examine the structure of these undergraduate programs and the level of exposure to mental health education in order to understand whether this has an impact on mental health stigma. Lastly, the results demonstrated no significant differences in stigma based on previous learning about mental health. However, preservice teachers who had learned about mental health before taking the course, had lower stigma at both the pre- and post-test than those who did not learn about mental health. Those who did not learn about mental health before the course showed the greatest reduction in stigma at the post-test. Nonetheless, even with previous mental health

training, a mental health course was beneficial in further reducing stigma. Overall, these findings are suggestive that a mental health literacy course helped reduce stigma among preservice teachers.

Mental Illness Stigma Theory. As previously discussed, the mental illness stigma theory provides a framework through which mental health stigma operates. The mental illness stigma theory discusses targeting public and self-stigma, through education, contact, and protesting (Corrigan & Watson, 2002b). The course that was delivered to preservice teachers used education and contact to target both public and self-stigma. The stigma measure also included statements that measured public and self-stigma. The education component in the course was delivered through lectures, assignments, quizzes, and discussions. The contact component included an indirect approach, through which students were assigned a fictitious student with mental health issues based on their division (i.e., primary/junior, intermediate/senior) and had to answer a series of discussion and quiz questions about their student. This allowed teachers to take a more practical approach in the course, through providing opportunities to understand how they would help students in their classroom with such issues. The findings in this research supported the mental illness stigma theory. Through providing education and contact to target stigma, we see that preservice teachers' stigma reduced following the completion of the course. These findings are important moving forward, in order to help researchers and educators understand and structure mental health courses that will target and reduce stigma among teachers.

The mental illness stigma theory also addresses stereotypes, prejudice, and discrimination in explaining how stigma operates (Corrigan & Watson, 2002b). In the Opening Minds Stigma Scale (Modgill et al., 2014), which was used in our study, the questions addressed all three of

these components through asking questions about mental health related to beliefs, feelings, and behaviours. Our findings demonstrated that stereotypes, prejudice, and discrimination are important components in how stigma operates. Teachers had more stigma at the start of the course compared to the end. Through debunking stereotypes and myths about mental health, teachers were given information to help them understand more about mental health, which we hope helped to change their beliefs in a more positive manner. This is informative in helping educators to structure courses, through including information which targets these three components. Lastly, our findings support the mental illness stigma theory, which supports that level of education influences peoples' attitudes towards mental health (Corrigan & Watson, 2002b). The preservice teachers who had prior education in mental health had less stigma at the pre- and post-test than those who had no education prior to the course. This demonstrates how education does have an influence on stigma and how continued education is beneficial to targeting stigma. It would be interesting to understand the long term effects of mental health education on stigma, through following up with teachers three to six months after the completion of the course.

Gender. In many professions, we see gender segregation continue to be present, in which some fields are male dominated and others are female dominated. Education, health, and caregiving are a few of the female dominated professions whereas math, engineering, and science are typically male dominated (Riegle-Crumb, King, Moore, 2016). In our research, the gender segregation was supported, in which the majority of preservice teachers completing the course were female. This is not uncommon given that teaching as a helping profession is female dominated. Therefore, the sample sizes for the data analysis were not changed in order to reflect the true nature of the teaching profession.

In examining stigma based on gender, the results showed that males had higher stigma than females and although males' stigma decreased, their stigma remained higher than the females at the post-test. Given this finding, it is important to consider whether men and women need to be targeted differently when educating them about mental health and stigma.

For many years, research has supported that men are socialized differently than women through the reinforcement of traditional gender norms. This conditioning involves the reinforcement of masculinity, which involves being strong and independent. Such norms can lead men to repress their emotions and feelings because not doing so would reflect weakness. This often translates into a lack of reporting of mental illness and low help-seeking behaviour among men. Expressing emotions such as pain, vulnerability, and loss, can represent a violation of gender constructs for some men (De Boise & Hearn, 2017; Yousaf, Popat, & Hunter, 2015). The subscription to these norms, can negatively influence mens' attitudes and perceptions towards help seeking behaviour. In fact, Yousaf et al. (2015), found that men had more negative attitudes about seeking help for mental health than did females. The authors connected this finding to masculinity attitudes, stating that "the reason why men hold more negative attitudes towards psychological help-seeking is their attitudes about how men should think and behave" (Yousaf et al., 2015, pg. 236).

Moreover, the results in Yousaf et al's (2015) study demonstrated that age had an impact on attitudes towards help-seeking. Younger men, had more negative attitudes towards help seeking than older men, which the authors associated with level of experience related to mental health. This is interesting to consider, as the males in our study can be presumed to be mostly younger, given the age trend in many postsecondary programs (Mackenzie, Gekoski, & Knox, 2006; Yousaf, et al., 2015). Interestingly, Mackenzie et al. (2006) found that higher education

had a positive impact on attitudes and help seeking behaviour among men, which “suggests that educational interventions designed to improve attitudes toward seeking psychological help might be most effective for the demographic group they would hope to target—men” (pg. 579).

Given this research, it is important to consider how men view mental health and stigma. It is possible that men showed higher levels of stigma at both the pre- and post-test because they have been socialized a certain way, which might be reflected in how mental health is viewed among some men. If this is the case, then it is important that mental health courses use this information to structure courses accordingly. This might include addressing these issues to bring into awareness the gender constructs that are embedded in our society and how this can impact our perception and implicit biases. De Boise & Hearn (2017) state that “understanding men’s emotions and getting men to understand emotions are vital in working with gender inequalities, as well as improving men’s wellbeing and health outcomes” (pg. 791). Overall, it might be beneficial to create a course that is more inclusive of how men and women might perceive mental health and stigma given the differences in gender constructs. In doing so, we hope to reduce stigma among preservice teachers and help them to form positive teacher-student relationships across genders.

Inclusive Practice. Inclusive practice is an important approach that has come up in discussion more frequently in school settings. Inclusive education, can be described as creating a classroom in which all students feel a sense of belonging despite their unique needs, which helps to “create a better quality of life for all our students—to bring them to a society that accepts difference” (Specht, 2012, pg. 45). This includes accepting differences in race, gender, ethnicity, socioeconomic status, ability, learning, and mental health. Research has supported that inclusive practice has significant impacts across students’ wellbeing, academic achievement, and mental

health (Specht, 2012). The course examined in this research was developed using principles of inclusion, given the importance inclusiveness has in the school setting and the impact it can have on students' wellbeing.

In implementing inclusive practice, education and training among teachers becomes important. In Specht's (2012) review of the literature, she states that teachers lack the necessary training and resources to implement inclusive education, which can have negative effects on students. In one study on inclusion, preservice teachers expressed reservations about their capabilities in adopting inclusive practices. Moreover, teachers were not confident in their understanding of inclusion (Specht, 2016). These findings demonstrate how important education is to providing teachers with resources to practice inclusiveness. Specht (2016) reports that, "teachers are more willing to adopt inclusive teaching practices, those which promote greater equity in classrooms of diverse learners, when they are comfortable with the use of appropriate pedagogy and when they believe that all students can learn and should be included in heterogeneous classrooms" (pg. 894). This means that empowering teachers through mental health education and training can provide them with the confidence to support students with mental health issues in their classrooms (Specht, 2016).

In connection with previous research, a lack of education and training can help to reinforce stigma, which can have negative implications. Stigma can be a barrier to adopting inclusive practices in the classroom, which is significant to consider. If teachers express stigma of mental health, then we might assume that students may experience exclusion in the classroom, given that stigma can often lead to discrimination. It is important that when discussing inclusiveness, mental health is considered given that it can lead to a sense of exclusion (Corrigan & Watson, 2002b). In considering the course examined in this research, mental health education

for teachers should be guided by principles of inclusion. This might include offering strategies to teachers that foster inclusiveness in the classroom, in order to ensure that all students feel a sense of belonging. Through implementing strategies that reinforce inclusive practice, teachers are promoting the wellbeing of their students to create a happier and safe environment for all.

Overall, offering education to teachers will help to support teachers' positive relationships in the classroom, reinforce inclusive practice and promote positive attitudes, and provide tools to adopt inclusiveness.

Limitations

There are limitations in this research that are important to consider. First, the preservice teachers in this sample are limited to teachers in their second year of teacher education at X University. This means that the findings are not necessarily generalizable to teachers who are practicing in the field. Next, there are a few threats to internal validity including history, maturation, and testing. Given that the pre- and post-test were taken 10 weeks apart, there are things outside of our control that could have affected the results due to history and maturation. For example, students could have taken additional seminars or workshops on mental health within the ten weeks.

Moreover, in between the ten weeks of the course, teachers were completing their practicums at their schools, which involved practicing teaching for approximately four weeks. This means that it is possible that the results were affected by other things such as professional development, interactions with students, and influence from associate and peer teachers. Thus, we cannot claim that the reduction of stigma was due to the course alone. Further, the testing effect could have influenced the results given that the preservice teachers took the pre-test at the start of the course and then took the same test 10 weeks later at the conclusion of the course. This

means that teachers were familiar with the questions. Overall, it is important to consider the above mentioned factors, which could have had an impact on the reduction of stigma.

Lastly, this research did not examine the effect of social desirability on the results. Social desirability is important to consider given that professionals are often reluctant to admit their true feelings due to the nature of their profession. This means that the preservice teachers could have misreported on the stigma measure, in order to appear desirable (i.e., social desirability bias). The pre- and post-test did include a social desirability measure, however, this was not included in the analyses for this specific research.

Strengths

There are strengths that are important to note as well in this research. First, there is limited research in the area of teachers and mental health stigma. Some research has been done that examines mental health stigma among practicing teachers, which had helped to support our research. However, there is no research that examines mental health stigma among preservice teachers in teacher education. Thus, this research is useful in helping researchers begin to understand how mental health literacy impacts stigma among preservice teachers.

Second, the sample size (N=263 at the pre-test; N=256 at the post-test) for this study was robust, which provided us with a significant amount of data to analyze. This helps to increase the reliability and validity of our findings. As mentioned earlier, the observed power in our findings was adequate at .88. This means that our results are more likely to be representative of meaningful differences in stigma rather than based on chance alone. Next, the measure Opening Minds Stigma Scale (Modgill et al., 2014), that we used in this research is a reliable and valid stigma scale, which helps us to be confident in our results. This scale has extensive research on

validating its utility. It is important that we used a valid and reliable stigma measure, given the importance stigma had in this research as the main variable being examined.

Lastly, the mental health literacy course that the preservice teachers completed, was the first mental health course that was made mandatory to complete as part of a Bachelor of Education program in Canada. This research was significant in examining the importance of mental health literacy and evaluating the effectiveness of the course across a number of areas such as reducing stigma. In examining the effectiveness of this course, educators will be able to determine what was done well and what needs to be improved to better meet the needs of preservice teachers. Further, this can help to guide the curriculum for future mental health literacy courses and potentially lead to the implementation of this course for preservice teachers across universities.

Implications

This research is a small portion of a broader research project that is looking at the overall implications of the mental health literacy course across a number of domains. Nonetheless, there are both theoretical and practical implications of this research. Theoretically, this research has contributed new findings to the area of mental health and stigma among preservice teachers. There is limited research in this area and thus, this study will help us begin to understand the impact of stigma and how we can begin to educate teachers. In a practical sense, this research has allowed us to take a first look at the implications of mental health education and its effect on stigma. Teachers spend a lot of time with their students, placing them in a position to both identify and support students' mental health needs. However, with limited training and the presence of stigma, some teachers might not be able to support them in the best manner. This means that it is important to understand how we can structure courses to meet the needs of

teachers and include the promotion of positive attitudes. In considering these findings and the findings of the larger research study, teacher education programs across universities might consider including a mandatory mental health literacy course. In doing so, we are helping our teachers help students and are providing them with the tools needed to support them.

There are also implications for counsellors to consider. Our role as counsellors should involve advocating for mental health education for all teachers. The role of psychology in school boards is important, in working to educate other professionals about mental health. This might include offering workshops to teachers and other staff about mental health or specific mental health topics. This also might include offering teachers the opportunity to speak with psychology staff about issues or concerns that arise with students. Our professional obligation involves advocating for the wellbeing of students, who might not have a voice to do so for themselves. Moreover, our role involves advocating for inclusive practice. This includes bringing awareness and understanding to the meaning of inclusive practice and what that can look like in the classroom through implementing various strategies to foster belonging and wellbeing.

Summary

In sum, teachers have a significant role in students' development and wellbeing. Research has found that students are increasingly dealing with mental health issues, however, a limited number of students receive proper support to deal with their struggles. This places teachers in a position to support students in the classroom. However, many teachers do not have the necessary training or education to help students with mental health issues in the classroom. This is important to consider as a lack of education in mental health can create stigma towards mental health. Mental health stigma is pervasive and can have serious effects including preventing individuals from seeking treatment and creating barriers to forming positive teacher-student

relationships. Moreover, stigma can operate implicitly, which might make it difficult for individuals to be aware of. This means that mental health education is important to provide to teachers, in order to reduce stigma and help them better support students in the classroom. Our findings demonstrate the significance of providing education to preservice teachers in reducing stigma over a period of time. In connection with previous research, it becomes apparent that it is important to begin implementing mental health courses for preservice teachers before entering the profession. This will help to provide teachers with appropriate and practical tools to deal with issues that might arise in the classroom.

Future research might include examining the impact of social desirability or implicit bias on stigma. Social desirability can influence the responses of preservice teachers on the stigma measure, given that teachers are in the helping profession and may want to represent themselves in a positive light despite their feelings towards mental health. Moreover, future research might include conducting a follow up measure a few months after preservice teachers complete the mental health literacy course. This would inform researchers of the long term effects of the course and whether or not the intensity of the course is enough to sustain the effects over time. Lastly, future research might include conducting interviews with preservice teachers in order to gain a deeper understanding of their perceptions around stigma as well as their experience in the course overall.

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Appendices

Appendix A: Demographic Questions

	Instructions	Please indicate, for each question, which response best describes you or your experience:
	17 items	
1	Gender	M F Transgender Prefer not to say
2	BEd program	Primary Junior Intermediate Senior Alternative Other
3	Cohort	International Education Early Childhood Education Urban Education French STEM Advanced Studies in the Psychology of Achievement, Inclusion and Mental Health
4	Previous degree	Science (biology, chemistry, physics, mathematics) Psychology Child and Family Studies Health Sciences (kinesiology, nursing, medicine) Social Sciences (geography, sociology, anthropology, Economics, Political Science) Arts & Humanities (English, History, Women's Studies, Philosophy, French...) Social Work Religion/Divinity Other (please specify)
5	Degree obtained	Highest degree obtained: Undergraduate Masters PhD Other (describe)
6	Prior learning about mental health	I have learned about mental health and mental illness before this course Y/N If yes, go to next question
7		If YES, choose one of the following:

		<p>Training Program (such as ASIST or Mental Health First Aid)</p> <p>Undergraduate course</p> <p>Post graduate course</p> <p>Other (describe)</p>
8	Student teaching experience	<p>Which of these describes your experience in your last practicum placement?</p> <p>Administrators were supportive of the needs of children and youth with mental health concerns.</p> <p>Administrators were supportive of the needs of teachers with mental health concerns.</p> <p>Teachers in the school were supportive of the needs of children and youth with mental health concerns.</p> <p>Teachers in the school were supportive of the needs of other teachers with mental health concerns.</p> <p>Other _____</p>

Appendix B: Opening Minds Stigma Scale



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

Opening Minds Scale for Health Care Providers (OMS-HC)

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If a colleague with whom I work told me they had a managed mental illness, I would be just as willing to work with him/her.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. If I were under treatment for a mental illness I would not disclose this to any of my colleagues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I would see myself as weak if I had a mental illness and could not fix it myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I would be reluctant to seek help if I had a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Employers should hire a person with a managed mental illness if he/she is the best person for the job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I would still go to a physician if I knew that the physician had been treated for a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. If I had a mental illness, I would tell my friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Despite my professional beliefs, I have negative reactions towards people who have mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. There is little I can do to help people with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. More than half of people with mental illness don't try hard enough to get better.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I would not want a person with a mental illness, even if it were appropriately managed, to work with children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Teachers do not need to be advocates for people with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I would not mind if a person with a mental illness lived next door to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I struggle to feel compassion for a person with mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix C: Course Syllabus

2

Learning Outcomes:

- How to **use** current research in teaching and learning.
- Child and adolescent **development** and student **transitions** from kindergarten to grade 12, and up to age 21.
- Educating students of a **program of professional education** in child, youth and parental mental health issues relevant to the elementary and secondary school environment in Ontario.
- The College's "Standards of Practice for the Teaching Profession" and "Ethical Standards for the Teaching Profession".
- Knowledge of the **Ontario context** in which elementary or secondary schools operate
- Ontario education law and related legislation, occupational health and safety legislation and legislation governing the regulation of the teaching profession in Ontario and the professional obligations of members of the College.
- **How to** create and maintain the various types of professional relationships between and among members of the College, students, parents, the community, school staff and members of other professions.

*Course Content: **Block 1: Oct. 18-Nov. 20: Mental Health and Mental Illness: What it is and is not***

Week 1: Mental Health at School: (Oct. 18)

- Social emotional development
- Language
- Mental health and mental health literacy
- Culture, social determinants of health and equity in access & support

Week 2: The Context of the Lives of Children, Youth and Teachers (Oct. 25)

- What comes to school with us
- The role of schools and teachers
- Trauma-informed teaching

Week 3: Mental Health in the Classroom (Nov. 1)

- Prevalence and onset of mental illness
- What good and poor mental health look like at work and at school
- The influence of mental health on learning and working

Week 4: Critical Issues (Nov. 8)

- The stigma of mental illness
- Diagnosis, treatment & outcomes
- Professional issues

Week 5: Stress (Nov. 15)

- Defining and describing risk
- Developing healthy coping strategies

Block two: January 10-February 12, 2017: Mental Health: What to ask, do and say***Week 6: Learning, Teaching and Working (Jan. 10)***

- Building relationships
- Creating and leading a mentally healthy classroom
- The Caring Adult

Week 7: Caring for students: Building Resilience and Responding to Challenges (Jan. 17)

- What to look for
- What to say
- Working with students, parents and the community

Week 8: Taking Action (Jan. 24)

- The role of the teacher
- Resources
- Pathways to care in your school/district

Week 9: Caring for ourselves: Building Resilience and Responding to Challenges (Jan. 31)

- Building awareness
- Self-care
- Working within the system

Week 10: Creating and Leading the Mentally Healthy Classroom (Feb. 7)

- Planning for a mentally healthy classroom
- Creating a mentally healthy classroom
- Knowing what is working, what needs attention

Course Materials:

Each week, core readings and resources will be provided on the course website. Students are encouraged to see out other sources of information (readings, video, or other resources) to personalize the course in a way that aligns with their approach to working with children and youth with mental health challenges.

Assignments and Other Course Requirements:***Preparation for Class***

This course is designed to be engaging and collaborative, and students will be expected to participate and contribute to one another's learning experience, and interact in online discussions with your instructor and your peers. Prior to each class, students are expected to have completed the readings and activities in order to engage thoughtfully in the online dialogue and get the most out of the course.

1. Students will complete a pre-test and post-test to track program efficacy in meeting course goals. These are not graded, but are considered participation. These will be completed via a link on the OWL site. The pre-test will be available for completion beginning at 8 am October 11, and close at 11:59 pm on October 17. There is no need to study any materials for this pre-test, it is merely a baseline. The post-test will be available at 8 am on February 6, 2017 and close at 11:59 on February 12, 2017. The pre-test and post-test are worth 7% each and students will receive 7 marks for completing each one (they will not be graded). (1 pre-test and 1 post-test x 7% each = 14% of final grade)
2. Students will complete weekly online quizzes weeks 2-10, based on material covered that week. These online quizzes will open at the beginning of each week (i.e. each Tuesday morning at 8 am) and close each Sunday evening at 11:59 pm. Students have 1 hour to take the quiz once they begin. While students may write it at any time during the time it is open, in order to have the complete 1 hour, they must start by 10:59 p.m. on the Sunday night of each week of the course (quizzes are written at the end of each week of the course). Quizzes will contain 8-10 questions each and each quiz is worth 4% of the final grade (9 quizzes x 4% each = 36% of total final grade). It is expected that students will complete quizzes independently.

Students will participate weekly in the Discussion Forums. Based on your program (P/J, J/I, or I/S), students will be assigned to smaller discussion groups of about 20 people (the same group for the whole course. Evaluation of your participation will be based on your ability to:

- Respond thoughtfully within each discussion;
- Make connections between the course content, readings and participants' discussion to date;
- Critique ideas, and build on responses of others;
- Raise probing questions that further the discussion;
- Communicate in a professional dialogue, which includes negotiating differences.
- Engage as an adult learner, responsible for taking and demonstrating initiative in the discussion in ways that foster a scholarly community of practice.
- Each week you will be required to respond to key questions, and provide meaningful feedback to the contributions of at least one of your peers. Original responses to each question must be 40-75 words, and feedback to peers must be 40 words or less.

The Discussion Forum opens each week at 8 am on the Tuesday and closes at 11:59 pm on the Sunday of the same week and is graded based on the criteria above; each week's participation is graded out of 4% (each week, 1 mark for answering each of 3 questions in 40-75 words, 1 for responding in 40 words or less to the post of at least one other member) (4% x 10 weekly discussions = 40% of final grade)

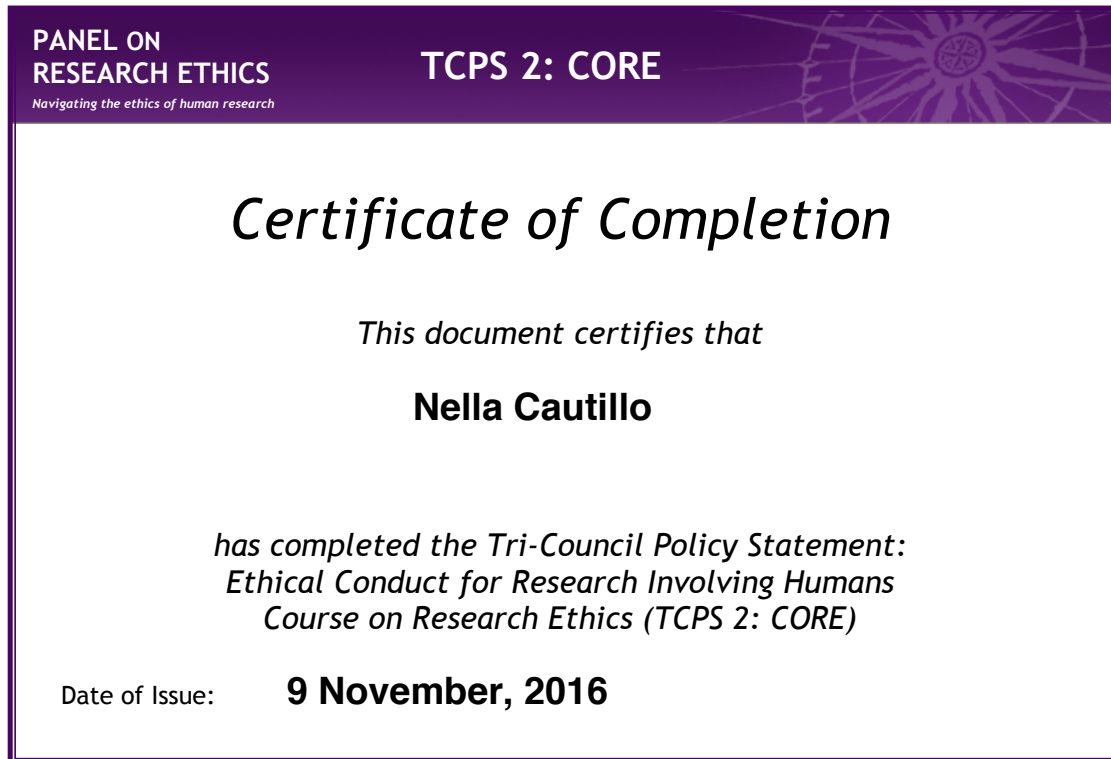
5

3. Twice during the year, by the end of Week 5 (11:59 pm on Nov. 20, 2016) and Week 10 (11:59 pm on February 12, 2017), students will complete brief video assignments and upload these to OWL. These assignments are worth 5% each and more details are found on the OWL site (2 videos x 5% each = 10% of final grade).

Summary of Assignments and Marks

Assignment	Type of Grade	Due Date	Value
Pre- test (no preparation required)	Participation	Pre-test: opens 8 am Oct. 11/16 and closes 11:59 pm Oct. 17/2016	7%
Online quizzes (weeks 2-10)	Graded for accuracy	Weekly	4% each, 36% of final grade
Discussion (weeks 1-10)	Participation, but evaluated using criteria seen in the description of assignments	Weekly	4% each, 40 % of final grade
Video assignments (2)	Evaluated based on criteria, details on OWL website	Nov. 20/2016 Feb, 12/2017	5% each, 10% of final grade
Post test	Participation	Post-test opens 8 am on Feb. 6/17 and closes 11:59 pm Feb. 12/2017	7%
			100%

Appendix D: Tri-Council Policy Statement



Curriculum Vitae

NAME Nella Cautillo

EDUCATION

2016-2018 Western University
London, Ontario, Canada
2016-2018 M.A.

2011-2015 Ryerson University
Toronto, Ontario, Canada
2011-2015 B.A.

AWARDS AND SCHOLARSHIPS

2016-2018 Admissions Scholarship
Western University

PROFESSIONAL AND RESEARCH EXPERIENCE

2017-2018 Intern: Here to Help Domestic Violence Program
Aisling Discoveries Child and Family Centre
Toronto, ON

2017-2018 Intern: Psychological Services
Dufferin-Peel Catholic District School Board
Brampton, Caledon, Mississauga, ON

2014-2016 Research Assistant
Ryerson University
Toronto, ON